

YOUTH EDUCATION PROGRAM
EMERGENCY CONTACT INFORMATION FORM
2011 –2012

NAME OF STUDENT/S:

1. _____ Grade: _____

2. _____ Grade: _____

3. _____ Grade: _____

Full name of 1st Emergency Contact: _____

Relationship to Student: _____

Home Phone: _____ Business Phone: _____

Cellular Phone: _____

Full name of 2nd Emergency Contact: _____

Relationship to Student: _____

Home Phone: _____ Business Phone: _____

Cellular Phone: _____

Name of Primary Doctor: _____

Doctor's Telephone: _____ Preferred Hospital: _____

Permanent Release: If and when the need for medical attention arises during the period of my child official participation in YEP program, and I can not be contacted, I hereby grant permission for my child to be treated by qualified medical authorities at their discretion.

Name: _____

Signature: _____ date: _____

IF NECESSARY, PLEASE FILL THE FOLLOWING PAGE FOR EACH CHILD
This information is confidential.

Name of Student: _____

Health Concerns: (Check all that apply)

Asthma ADD ADHD LD OTHER

Allergies: _____

If your child takes medication regularly, please let us know.

Please indicate any other health information:

Parent's signature _____ Date _____